TEXAS
Department of
Human Services

COMMISSIONER
James R. Hine

February 2, 2004

To: Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) Providers
Community Care for the Aged & Disabled (CCAD) Residential Care (RC) Providers

Subject: Long Term Care (LTC)
Information Letter No. 04-08
Revisions to Assisted Living And Residential Care Fiscal and Contract Compliance Guides, Effective March 1, 2004

As a result of the Texas Department of Human Services (DHS) adoption of the new Chapter 46 "Contracting to Provide Assisted Living and Residential Care Services", the attached Form 3240, Assisted Living/Residential Care Fiscal Monitoring Guide and Form 3241 Assisted Living/Residential Care Contract Compliance Monitoring Guide have been revised. The forms now include new and revised monitoring standards which are consistent with the new program rules provided with LTC Information Letter 03-14.

Effective November 1, 2003, DHS suspended monitoring reviews for all CCAD RC and CBA AL/RC providers. DHS staff will begin using the revised Form 3240 and Form 3241 with reviews to be conducted beginning March 1, 2004. The revised forms and instructions can be accessed March 1, 2004 at the website below.

http://www.dhs.state.tx.us/programs/communitycare/forms/index.html

Revisions to each form is summarized below:

Form 3240 – Assisted Living and Residential Care Fiscal Monitoring Guide:

General Changes

- Changed the title from Assisted Living/Residential Care Fiscal Monitoring to Assisted Living And Residential Care Fiscal Monitoring Guide.
- Removed Standard I and Standard II and moved them to Contract Compliance Guide, Form 3241.

- Revised the Financial Error Standard Chart.
- Moved financial errors 3 and 4 to administrative errors 10 and 11.
- Financial error 3 was replaced with financial errors 3 and 4.

Form 3241 - Assisted Living and Residential Care Contract Compliance Monitoring Guide:

General Changes

- Changed the title from Assisted Living/Residential Care Compliance Monitoring Guide for Contract Performance Standards to Assisted Living And Residential Care Contract Compliance Monitoring Guide.
- Renamed and renumbered each standard.
- Added the following standards:
  - Standard 1 – Residence Settings
  - Standard 2 – Service Initiation
  - Standard 4 – Co-payment / Room & Board Ledger
  - Standard 5 – Service Delivery Documentation
  - Standard 8 – Facility Standards
- Deleted Residential Care Provider manual references and replaced them with new TAC rule references.

Regional contract managers have been offering training to facilities on the revised Form 3240 and Form 3241. Facilities are responsible for complying with the new Chapter 46 rules effective September 1, 2003.

Please contact your contract manager if you have any questions regarding this information. Contract managers may contact Lettie Ojeda at (512) 438-4768 for any questions.

Sincerely,

Signature on file

Marilyn Eaton
Director
Long Term Care Services

ME:lo

Attachments - 4

c: RAs
RDs
Reg & SO LTC Trainers
SO Staff

ASSISTED LIVING AND RESIDENTIAL CARE FISCAL MONITORING GUIDE

Client Name	Medicaid No.	Date of Review (MM/DD/YY)	Review Month (MM/YY)

Review Type	Service And Setting Type	Service Code	Region	Co-payment
☐Formal ☐Follow-Up	☐CCAD RC_____ ☐CBA AL/RC_____	_____		$

Vendor No.	Facility Name	Monitor

FINANCIAL ERROR STANDARD				
A. Number of Days Reimbursed:	**B. Daily Rate:** **X $**	**C. Subtotal (A X B)** **= $**	**D. Co-payment** **$**	**E. Reimbursed** **(C minus D) = $**
F. Number of Days Served:				
G. Number of Days Over billed: **(A minus F) =**	**H. Daily Rate:** **X $**	**I. Subtotal (G X H)** **= $**	**J. Prorated Co-pay** **$**	**K. Total Recoupment** **(I minus J) = $**

EXPLANATION OF FINANCIAL ERRORS	ATTENDANCE RECORD PERIOD & UNITS IN ERROR
REFERENCE: 40TAC §46.23(2)(A)	
1. The facility is reimbursed for services, but the daily census documentation and the daily service delivery documentation are missing for the period for which services are reimbursed. DHS applies the error to the total number of units reimbursed for the billing period for which forms are missing.	
2. The facility is reimbursed for units that exceed the units recorded on the daily census documentation and daily service delivery documentation. DHS applies the error to the total number of units reimbursed in excess of units recorded.	
3. The facility is reimbursed for units of service and the client did not receive services. DHS applies the error to the total number units reimbursed for the days the client did not receive services.	
4. The facility is reimbursed for units of service and the client was Medicaid ineligible (applicable to CBA Assisted Living/Residential Care). DHS applies the error to the total number units reimbursed for the days the client was Medicaid ineligible. **This does not apply to the Community Care for Aged and Disabled (CCAD) Residential Care (RC) Program.**	
TOTAL NUMBER OF UNITS IN ERROR:	
TOTAL AMOUNT FOR RECOUPMENT:	(Units x Rate - Copay) $

Comments:

Client Name	Medicaid No.

ADMINISTRATIVE ERROR STANDARD	
EXPLANATION OF ADMINISTRATIVE ERRORS	**ATTENDANCE RECORD PERIOD & UNITS IN ERROR**
REFERENCE: 40TAC §46.23 (2)(B)	
1. The facility enters a date of signature on the daily census documentation that is before the date of the last day services are provided. DHS applies the error to the total number of units reimbursed after the signature date.	
2. The facility fails to sign the daily census documentation. DHS applies the error to the total number of units reimbursed on the unsigned form.	
3. The facility fails to enter a date of signature on the daily census documentation to certify total number of units provided to the client. DHS applies the error to the number of units reimbursed on the undated form.	
4. The facility corrects the date of signature on the daily census documentation, but fails to initial the correction. DHS applies the error to the total number of units reimbursed after the earliest signature date.	
5. The facility uses a signature stamp on the daily census documentation, but fails to initial the stamped signature. DHS applies the error to the total number of units reimbursed on the signature stamped form.	
6. The facility makes an illegible entry or illegible correction to any portion of the record of time of the daily census documentation. DHS applies the error to the total number of units reimbursed for the days in which entries are illegible.	
7. The facility enters an illegible date of signature or makes an illegible correction to the date of signature on the daily census documentation. DHS applies the error to the total number of units on the form.	
8. The facility fails to complete the entire daily census documentation in ink. DHS applies the error to the total number of units reimbursed that were not completed in ink.	
9. The facility uses a method other than crossing out and initialing to change an entry on the daily census documentation. DHS applies the error to the total number of units reimbursed that were corrected in a manner other than crossing out and initialing.	
10. The facility fails to list the client on the daily census documentation, but the client was listed on the daily service delivery documentation. The department applies the error to the total number of units reimbursed for the period the client was left off the Daily Census Record form.	
11. The facility leaves the daily status blank on the daily census documentation, but daily activity can be verified on the daily service delivery documentation. DHS applies the error to the total number of units reimbursed for which the daily status is left blank on the daily census documenation.	
RECOUPMENT UNITS:	
RECOUPMENT AMOUNT:	(Units x Rate – Copay) x 12% $

ASSISTED LIVING AND RESIDENTIAL CARE FISCAL MONITORING GUIDE

PURPOSE

To serve as the primary document to record findings of fiscal monitoring reviews of Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) and Community Care for the Aged and Disabled (CCAD) Residential Care (RC) providers.

PROCEDURE

When to Prepare

DHS staff who conduct the monitoring complete the form for each case read.

Number of Copies

Complete one original for each case read.

Transmittal

DHS staff will retain the original for DHS records. A copy of the form is given to the facility if requested only after the monitoring results have been finalized.

Form Retention

Retain this form according to the terms in the *Community Based Alternatives Provider Manual* and the *Residential Care Provider Manual*.

Supply Source

This form must be printed from the electronic version of the DHS Forms Website.

DETAILED INSTRUCTIONS

Client Name — Enter the client's name as it appears on page 1 of the participant's Form 3671, Individual Service Plan (ISP), or Form 2101, authorization for Community Care Services – Service Authorization System (SAS).

Medicaid No. — Enter the Medicaid recipient number as it appears on Form 3671, page 1, or on Form 2101.

Date of Review – Enter the date the review is being conducted for this client's file in month/day/year (MM/DD/YY) format.

Review Month — Enter the month and year being reviewed in month/year (MM/YY) format.

Review Type — Check the type of review being conducted: Formal or Follow-up.

Service And Setting Type – Check the type of service being reviewed: CCAD RC or CBA AL/RC.

Next to the service type, enter the authorized setting as follows:

CCAD RC –

- Apt. = Apartment
- Non-Apt. = Non-Apartment

CBA AL/RC –

- AL Apt. = Assisted Living Apartment
- RC Apt. = Residential Care Apartment
- RC Non-Apt. = Residential Care Non-Apartment

Service Code - Enter the service code that is data entered in COGNOS - Payments for Monitoring.

Region - Enter the number of the region to which the facility is assigned.

Co-payment - Enter the authorized co-payment for the month being reviewed, as found on Form 2065-B, Notification of CBA Services, or Form 2065-A, Notification of Community Care Services.

Vendor No. — Enter the vendor number of the facility being reviewed.

Facility Name — Enter the name of the facility being reviewed.

Monitor — Enter the name of the DHS staff conducting the review for this client's file.

FINANCIAL ERROR STANDARD

A. Enter the number of days DHS has reimbursed the facility for the review month.
B. Enter the authorized daily rate for the client.
C. Enter the total of A times B.
D. Enter the client's authorized co-payment amount for the review month.
E. Enter the total of C minus D.
F. Enter the total number of days the client was served by reviewing the daily census documentation and the daily service delivery documentation.
G. Enter the total of A minus F.
H. Enter the daily rate the facility billed DHS for the client during the review month.
I. Enter the total of G times H.
J. Enter the prorated co-payment amount. (Authorized Co-payment for the month divided by the number of days in the review month times the number of days the facility over billed).
K. Enter the total of I minus J.

EXPLANATION OF FINANCIAL ERRORS

For Items 1 through 4, enter the number of units in error for each item, and the attendance record period on which it appears.

Total Number of Units In Error — Enter the total number of units in error. Financial errors result in 100% recoupment of the units in error. Only recoup one error per client per day.

Total Amount for Recoupment — Enter the total amount for recoupment due to financial errors. To calculate this amount, multiply the units in error for the service code by the daily rate and subtract the prorated co-payment for that number of units..

NOTE: For units found to be in error outside the sample, please complete a separate form and note on the bottom of the page that these units are outside of the sample.

ADMINISTRATIVE ERROR STANDARD

For Items 1 through 11, enter the number of units in error for each item, and the attendance record period on which it appears. Administrative errors result in 12% recoupment of the units in error.

Recoupment Units — Enter the number of units in error. If there are any financial errors for a day that there is an administrative error, do not recoup the administrative portion.

Recoupment Amount — Multiply the number of units in error for each service code by that daily rate, deduct the copay applicable to that number of units, and multiply the result by 12%.

NOTE: For units found to be in error outside the sample, please complete a separate form and note on the bottom of the page that these units are outside of the sample.

Texas Department of Human Services

ASSISTED LIVING AND RESIDENTIAL CARE CONTRACT COMPLIANCE MONITORING GUIDE

Form **3241**
March 2004

Client Name	Medicaid No.	Date of Review (MM/DD/YY)		Review Period (MM/YY)
Review Type ☐**Formal** ☐**Follow-Up**	Service And Setting Type ☐**CCAD RC:** _____ ☐ **CBA AL/RC:** _____	Service Code	Region	Co-payment (If Applicable)
Vendor No.	Facility Name	Monitor		No. Contracted Beds

STANDARDS CRITERIA	YES	NO	N/A	NOTES
STANDARD 1 – Residence Setting				
a. Does this client reside in a room that meets the requirements the facility is billing for?…… **If YES, continue to item b.** **If NO, Standard 1 is NOT MET, continue to item b.**	☐	☐	☐	**View the facility floor plan to verify location of client's residence.** Square Footage: _____ Date Contract Awarded: _____ Meets Requirements (Y/N)? _____
b. Does this client share an Assisted Living Apartment?……. **If YES, continue to b.1.** **If NO, mark b.1. N/A., continue to Standard 2.** 1. Did the client request double occupancy in writing? **If YES, continue to Standard 2.** **If NO, Standard 1 is NOT MET, continue to Standard 2.** **REFERENCE: 40 TAC §46.13 (a)**	☐ ☐	☐ ☐	☐ ☐	Date of Written Request:
	MET	**NOT MET**	**N/A**	
STANDARD 1 IS:	☐	☐	☐	
STANDARD 2 – Service Initiation				
Was the initial assessment due or completed within the review period? ..... **If YES, continue to item a.** **If NO, mark Standard 2 N/A, skip to Standard 3.**	☐	☐	☐	
a. Did the client/client's representative and facility sign a written agreement before or at the time of admission?…… **If YES, continue to items a.1.- 5.** **If NO, Standard 2 is NOT MET, continue to item b.**	☐	☐	☐	Date of Admission (daily census documentation): Date Agreement Signed:
Did the agreement include the following:				
1. Bed-hold policies for hospital/nursing facility stays?……	☐	☐	☐	
2. Personal leave policies and charges?……	☐	☐	☐	**The facility must not charge for any service provided as required by its contract.**
3. Eviction procedures?……	☐	☐	☐	
4. All available services in the facility?……	☐	☐	☐	
5. Charges for services not paid by DHS?	☐	☐	☐	
REFERENCE: 40 TAC §46.39(c)(1-5) **If any item in a. is marked NO, Standard 2 is NOT MET, continue to item b.**				
b. Was the health assessment and individual service plan completed within 72 hours of the client's admission to the facility by the appropriate person(s)?…… **REFERENCE: 40 TAC §46.39(d)(3)** **If NO, Standard 2 is NOT MET, continue to Standard 3.**	☐	☐	☐	Date of Admission (daily census documentation): Assessment Date and Time: **Health Assessment and individual service plan must be completed by the facility manager or nurse as appropriate. <u>For CBA AL/RC:</u> the medication administration portion of the assessment must be completed by a nurse and signed off by an RN.**
	MET	**NOT MET**	**NA**	
STANDARD 2 IS:	☐	☐	☐	

Standard Summary: (optional) **Std 1:** _____ **Std 2:** _____ **Std 3:** _____ **Std 4:** _____ **Std 5:** _____ **Std 6:** _____ **Std 7:** _____

Client Name: _____

STANDARDS CRITERIA	YES	NO	N/A	NOTES
STANDARD 3 – Co-payment and Room and Board Ledgers				
Did the facility maintain a ledger for the client?…… **If YES, continue to items a.1.- 4.** **If NO, Standard 3 is NOT MET, skip to Standard 4.**	☐	☐	☐	
a. Does the ledger system reflect the following for this client: 1. All charges for co-payment **and** room and board?…… 2. All payments for co-payment **and** room and board made by or on behalf of the client?…… 3. All credits, if any, including the specific amount credited, month and year of the coverage period of the credit, type of payment credited and the reason for the credit?…….. **4.** A running balance?…… **REFERENCE: 46.37(e)(2-3)** **If any item in a.1.- 4. is marked NO, Standard 3 is NOT MET, continue to item b.**	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	**Mark items a. 1. – 4. YES, if the element can be found in any format.**
b. Were all activities recorded in the ledger system within 35 days or by the next billing cycle, (whichever is sooner) of date collected?…… **REFERENCE: 46.37(e)(2-3)** **If YES, continue to Standard 4.** **If NO, Standard 3 is NOT MET, skip to Standard 4.**	☐	☐	☐	
	MET	**NOT MET**	**NA**	
STANDARD 3 IS:	☐	☐	☐	
STANDARD 4 – Co-payment and Room and Board Refunds				**Complete the table below, then answer item a. as instructed.**
a. Did the client enter an institution during the review period or one month prior to the review period?..... **If YES, continue to item a.1.** **If NO, mark item a.1. N/A, skip to item b.**	☐	☐	☐	
NOTE: The facility must refund the client's co-payment for the days the client uses institutional leave. **For CCAD RC:** the facility must refund any co-payment received that is in excess of the bed hold amount. **For CBA AL/RC:** the facility must refund all co-payments received.				
1. Did the client's institutionalization result in a credit balance?…… **If YES, continue to item A.** **If NO, mark item A. and B. N/A and skip to item b.**	☐	☐	☐	
A. Did the facility provide written client notice within 35 days of receipt of the payment that resulted in a credit balance?…… **If YES, continue to item B.** **If NO, Standard 3 is NOT MET, mark item B. N/A, skip to item b.**	☐	☐	☐	
B. If the client/client's representative did not respond to the written client notice, did the facility provide a refund of the credit balance or apply the credit balance to the following month's payment **and** was notification of the action sent?…….. **REFERENCE: 40 TAC §46.37(c)(2)(A), (C)** **If YES, continue to item b.** **If item B. is marked NO, Standard 4 is NOT MET, continue to item b.**	☐	☐	☐	

Review Period (MM/YY):			
A. Authorized Co-payment:			
B. Co-payment Refund: (from previous month)			
C. Adjusted Amount Due: (A minus B)			
D. Amount Collected:			
E. Credit Balance (+) OR Underpayment (-) : (D-C)			
Date of *Written Notice of the Credit Balance: (If Applicable)			

Date of payment that resulted in a credit balance: _____

# of Days it took to send Written Notice: _____

***The written client notice can be in the form of a monthly statement so long as it specifies the credit balance. The client notice must offer the following options to the client/client's representative:**

- **Pay correct amount and facility to return the original amount paid;**
- **Refund of the credit balance;**
- **Have the credit balance applied to specified month(s)**

If the client was institutionalized and does not have a co-payment, mark items 1., item A. and item B. N/A

Client Name:

STANDARDS CRITERIA	YES	NO	N/A	NOTES
b. Was the client discharged/deceased during the review period?……. **If YES, continue with item b.1.** **If NO, mark item b.1. NA, skip to Standard 5.**	☐	☐	☐	
1. Did the facility refund the client's co-payment and room and board for the remaining days of the month following the date of discharge or death within ten working days of awareness?…… **REFERENCE: 40 TAC §46.37(f)** **If NO, Standard 4 is NOT MET, continue to standard 5.**	☐	☐	☐	**The facility must document the date of awareness of client's discharge.**
	MET	**NOT MET**	**N/A**	
STANDARD 4 IS:	☐	☐	☐	
STANDARD 5 – Co-payment and Room and Board Receipts				
a. Did the facility designate, in writing, a due date for co-payment and room & board? ..... **If YES, continue to item a.1.** **If NO, Standard 5 is NOT MET, skip to item b.**	☐	☐	☐	Review Period (MM/YY): | Co-payment Due Date: | Date Co-Payment Collected: | Room & Board Due Date: | Date Room & Board Collected:
1. Did the facility collect the **entire** co-payment and entire room and board on or before the designated due date?…… **If YES, mark item a.2. N/A, skip to item b.** **If NO, continue to item a.2.**	☐	☐	☐	**The due date must be during the same month it is applied. If the due date falls on a holiday or weekend, the facility must collect the entire amount on or before the first working day thereafter.**
2. Did the facility notify the client/client's representative and the case manager in writing no later than the first working day after the due date?…… **REFERENCE: 40 TAC §46.37(b)(1-3)** **If NO, Standard 5 is NOT MET, continue to item b.**	☐	☐	☐	Date of written notice to client/client's representative: Date of written notice to case manager:
b. Did the facility keep a copy of co-payment and room and board receipts?…… **If YES, continue to items b.1.- 4.** **If NO, Standard 5 is NOT Met, skip to Standard 6.**	☐	☐	☐	**Mark items b. 1.-4. YES, if the element can be found in any format.**
Do the receipts contain the following elements:				
1. The name of the client?……	☐	☐	☐	
2. The month, day, and year the payment was received? ….	☐	☐	☐	
3. The total amount collected for co-payment and the total amount for room and board?…….....	☐	☐	☐	Must specify amount for each co-payment **and** room and board collected.
4. The month and year of the coverage period for the payment received?…… **REFERENCE: 40 TAC §46.37(d)(2-3)** **If all items are marked YES, continue to standard 6.** **If any item b.1.- 4. is marked NO, Standard 5 is NOT MET, continue to Standard 6.**	☐	☐	☐	
	MET	**NOT MET**	**N/A**	
STANDARD 5 IS:	☐	☐	☐	

Client Name:

STANDARDS CRITERIA	YES	NO	N/A	NOTES
STANDARD 6 – Service Delivery Documentation				
a. Does the daily service delivery documentation used by the facility contain the following:				Mark an X by any missing information during review period if any:
				Review Period (MM/YY):
1. The client name?	☐	☐	☐	
2. Facility vendor number issued by DHS?	☐	☐	☐	
3. The coverage period?	☐	☐	☐	
4. Tasks assigned?	☐	☐	☐	
5. Tasks performed during the coverage period?	☐	☐	☐	
6. Facility Manager or Supervisor signature & date?	☐	☐	☐	Signature date (MM/DD/YY):
REFERENCE: 40 TAC §46.19(c) **If any item in a.1.- 6. is marked NO, Standard 6 is NOT MET, continue to item b.**				
b. Did the facility provide services according to the service plan completed for the client? **REFERENCE 40 TAC §46.41(a)** **If NO, Standard 6 is NOT MET, continue to item c.**	☐	☐	☐	**Review the service plan and service delivery documentation. List the specific dates that services were not provided according to the service plan:**
c. Does the service delivery documentation reflect any changes in assigned tasks? **If Yes, continue to c.1.** **If No, mark item c.1 and c.2. N/A and skip to item d.**	☐	☐	☐	
1. Was a new service plan developed?	☐	☐	☐	Date of Assessment:
2. Was the service plan change implemented within 7 days of the assessment date? **REFERENCE 40 TAC §46.43(a-b)** **If item c.1. or c.2. is marked NO, Standard 6 is NOT MET, continue to item d.**	☐	☐	☐	Date change implemented:
d. Did the facility conduct and document checks or visits made as identified on the service plan completed for the client? **REFERENCE 40 TAC §46.41(b)(1)(I)** **If NO, Standard 6 is NOT MET, continue to item e.**	☐	☐	☐	**Twenty-four-hour supervision: the facility must document checks/visits in the client file.** **Mark this item N/A if documentation indicates client requests no checks/visits.**
e. Did the facility notify the case manager, orally or by facsimile no later than one DHS workday after any of the circumstances described in §46.45, Required Notifications occurred?	☐	☐	☐	Briefly explain what occurred and Date of occurrence: Date case manager notified:
1. For notifications done orally, did the facility send written notification to the case manager within 5 working days of the initial notification? **REFERENCE 40 TAC §46.45(a-b)** **If e. or e.1. is marked NO, Standard 6 is NOT MET.** **Mark N/A if no circumstances occurred. Continue to item f.**	☐	☐	☐	Date of written follow-up (if applicable):
f. Did the facility notify the case manager, orally or by facsimile no later than one DHS workday after any of the circumstances described in §46.47, Suspension of Services occurred?	☐	☐	☐	Briefly explain the suspension and Date of Suspension: Date case manager notified:
1. For notifications done orally, did the facility send written notification to the case manager within 5 working days of the initial notification? **REFERENCE 40 TAC §46.47(a-b)** **If item f. or f.1 is marked NO, Standard 6 is NOT MET.** **Mark N/A if there were no suspensions during review period.**	☐	☐	☐	Date of written follow-up if applicable:
	MET	**NOT MET**	**N/A**	
STANDARD 6 IS:	☐	☐	☐	

Client Name:

STANDARD 7 – Individual Client Trust Fund

A. Does the facility provide assistance in the management and safeguarding of the client's trust fund?..... ☐ YES ☐ NO

If NO, mark Standard 7 N/A, skip to Standard 8. If YES, continue and complete for the review period:

ITEM	AMOUNT
1. **Beginning Ledger Balance –** Use the previous month's trust fund balance from the client ledger. If there are adjustments made to clear any exceptions taken in previous monitoring either: a. Use the **Monitoring Ending Balance** without including any deposits or adjustments, **or** b. Use the **Facility Ending Balance** and include any increases resulting from clearance from prior exceptions as deposits, and any decreases resulting from clearance as withdrawals**.** ……	
2. **Total Monies Deposited –** Review the client's trust fund deposit receipt book and deposit slips. Use Form 3240-A, Client Evaluation Worksheet, and record every receipt/deposit in the review period made to the client's account and the date of each receipt. Add all receipts/deposits and enter the total **here**……	
3. **Total Withdrawals –** Review the client's individual ledger. Use Form 3240-A, Client Evaluation Worksheet. Record every withdrawal made from the client's account in the review period and the date of the withdrawal. Enter total here……	
4. **Monitored Balance Prior to Unauthorized Withdrawals –** The balance shown in this item should be the same as the balance shown at the end of the review period on the client ledger, unless there has been an error in math by the facility or the monitor. If the error was made by the facility, they must correct the error on the ledger. **The Monitored Balance Prior to Unauthorized Withdrawals is computed as follows:** **Beginning ledger Balance** (Item 1) **+ Total Monies Deposited** (Item 2) **– Total Withdrawals = (enter here)**……..	
5. **Unauthorized Withdrawals –** The prerequisites of a withdrawal from the client's trust fund are: a. The purchases should be authorized by and for the benefit of the client; b. The cost should be reasonable; and c. The facility should not profit from the transaction. Verify that each withdrawal is authorized. If it is not, check the "NO" box in Section B of Form 3240-A and enter in the Comments section: **Payee Name and reason it is an unauthorized withdrawal.** Total the amounts of any unauthorized withdrawals and enter that total here……..	
6. **Monitored Ending Balance – The Monitored Ending Balance is computed as follows:** **Balance Prior to Unauthorized Withdrawals** (Item 4) **+ Unauthorized Withdrawals** (Item 5) **= (enter here)**…….	
7. **Facility Ending Balance – Enter the balance of the client's trust fund ledger** ……	
8. **Differences –** Enter the difference between the **Monitored Ending Balance** (Item 6) and the **Facility Ending Balance** (Item 7) as follows: If the Monitored Ending Balance **equals** the Facility Ending Balance, enter a zero. If the Monitored ending Balance **is less than** the Facility Ending Balance, enter the figure as a credit (bracketed). If the Monitored Ending Balance **is more than** the Facility Ending Balance, enter the figure as a positive amount**…**…….	

B. EVALUATION **REFERENCE:40 TAC §46.61, §46.65, §46.71**	**YES**	**NO**	**N/A**	**COMMENTS/NOTES**
1. Written documentation authorizing the facility to handle the client's financial affairs is on file……	☐	☐	☐	
2. Deposits are properly posted to the client's trust fund account within the specified time frames and are supported by receipts/deposit slips……	☐	☐	☐	
3. Only authorized charges were made to the client's trust fund account……	☐	☐	☐	
4. Payments/withdrawals are supported by required documentation……	☐	☐	☐	
5. Client's trust fund account balance for the period reviewed is accurate according to deposits/withdrawals recorded to account……	☐	☐	☐	
6. Discharged/deceased client's trust funds balance were refunded properly within specified time frames……	☐	☐	☐	
If any item in B. is marked NO, Standard 7 is NOT MET, continue to Standard 8.	**MET**	**NOT MET**	**N/A**	
STANDARD 7 IS:	☐	☐	☐	

Facility Name:	**Vendor Number:**

Review Period (MM/DD/YY): **From:** **To:**	**Review Date (MM/DD/YY):**	**Monitor:**

STANDARDS CRITERIA	YES	NO	N/A	NOTES
STANDARD 8 – Pooled Client Trust Fund				**This Standard is reviewed only once for the facility.**
A. Does the facility maintain a pooled trust fund account for clients?..... ☐ YES ☐ NO If NO, mark Standard 8 N/A, skip to standard 9. If YES, continue and complete for the review period:				
B. EVALUATION **REFERENCE: 40 TAC §46.63**				**The facility must maintain trust fund records as described in 40 TAC 46 Subchapter D, Trust Funds.**
1. Client's trust fund is separate from other facility accounts?.....	☐	☐	☐	
2. Interest earned on pooled interest bearing account is prorated to each client's account by an acceptable method?.....	☐	☐	☐	
3. Are the balances shown in the bank statements supported by the ledgers for all clients utilizing the pooled account?	☐	☐	☐	
4. Did the facility record transactions within 14 days of occurrence?.....	☐	☐	☐	
REFERENCE: 40 TAC 46.63(a)(1),(d) 46.65(a)(4) **If any item in B. is marked NO, Standard 8 is NOT MET**	**MET**	**NOT MET**	**NA**	Do not include the findings for Standard 8 in determining the compliance level for the facility. Report Standard 8 findings separately in the findings section below. Request that the facility develop a corrective action plan if compliance with Standard 8 is NOT MET.
STANDARD 8 IS:	☐	☐	☐	

Findings:

Monitor-Signature **Date** **Facility Representative-Signature** **Date**

Facility Name:

STANDARDS CRITERIA	YES	NO	N/A	NOTES
STANDARD 9 – Facility Standards				**This Standard is reviewed only once for the facility.**
a. Did the facility provide at least four social /recreational activities per week **and** post a monthly activity calendar at least one week in advance? ..... **REFERENCE 40 TAC §46.41(b)(4)** **If YES, continue to item b.** **If NO, Standard 9 is NOT MET, continue to item b.**	☐	☐		Date calendar was posted for the current month:
b. Did the facility ensure the number of DHS clients served by the facility did not exceed the number of contracted DHS beds during the review period?..... **REFERENCE: 40 TAC §46.11(b)(3)(B)** **If YES, continue to item c.** **If NO, Standard 9 is NOT MET, continue to item c.**	☐	☐		# of DHS Clients Per COGNOS: No. of Beds: Daily census documentation:
c. Did the facility ensure that the Assisted Living Disclosure Statement does not conflict with the program requirements? **REFERENCE: 40 TAC §46.11(c)** **If YES, continue to item d.** **If NO, Standard 9 is NOT MET, continue to item d.**	☐	☐		
d. Does the facility maintain a log of the complaints and make review of complaints accessible to the contract manager?..... **REFERENCE: 40 TAC §49.17(d)(3)** **If NO, Standard 9 is NOT MET, continue to item e.**	☐	☐		
e. Were there complaints during the review period? ..... **If YES, complete the table below then continue to item f.** **If NO, skip item f.**	☐	☐		

List **any** DHS clients with any complaints received by the client/client's representative or any other party on behalf of the client received during the review period. Do not list the complainant name, only the DHS client's name. Attach additional pages as needed.

Client Name:	Date Complaint Received:	Date Investigation & Resolution Completed:	Date Services Began (for initial cases):	Date of Most Recent Notification of Procedures:	Date of Previous Notification of Procedures:	Completed* Timely (Y/N):

NOTE: *Completed Means:

- Investigated and resolved in accordance with applicable licensure rules or if no such rules, within five workdays of receipt of the complaint**.**
- Obtaining the client/client's representative initials on client-initiated complaints or a witness's signature when the client refuses to sign, and
- Providing complaint procedures to clients/client's representatives in writing no later than the time services begin (for initial cases) and no more than 12 months between each notification (for ongoing cases).

f. Is there documentation that the facility:				
1. Investigated and resolved all complaints in accordance with applicable licensure rules, or if no such rules, within 5 workdays of receipt of the complaint?	☐	☐		**If any complaint that is received from a sample or a non-sample client during the review period is not completed timely, mark either f.1 or f.2. as applicable, NO.**
2. Were procedures on complaints provided to each client/client's representative in writing no later than the time services began (for initial cases) and no more than 12 month between each notification (for ongoing cases)? **REFERENCE: 40 TAC §49.17(a-f), §49.18(a),(d)** **If either item f1 or f2 is marked NO, Standard 9 is NOT MET**	☐	☐		Do not include the findings for Standard 9 in determining the compliance level for the facility. Report Standard 9 findings separately in the Findings section of Form 3853.
STANDARD 9 IS:	**MET** ☐	**NOT MET** ☐		Request that the facility develop a corrective action plan if compliance with Standard 9 is NOT MET.

ASSISTED LIVING AND RESIDENTIAL CARE CONTRACT COMPLIANCE MONITORING GUIDE

03-2004

PURPOSE

To serve as the primary document to record findings of contract compliance monitoring of Community Based Alternatives (CBA) Assisted Living/Residential Care (AL/RC) and Community Care for the Aged and Disabled (CCAD) Residential Care (RC) providers.

PROCEDURE

When to Prepare

DHS staff who conduct the monitoring complete Standards 1 - 7, for each case read, and Standards 8-9 once for each contract. A separate monitoring form should be completed for each CBA AL/RC and CCAD RC Vendor Number.

Number of Copies

Complete one original page for Standards 1 - 7 for each case read, with the exception of Standards 8-9, which is only completed **once** during the review.

Transmittal

DHS staff will retain the original for DHS records. A copy of the form is given to the facility if requested only after the monitoring results have been finalized.

Form Retention

Retain this form according to the terms in the *Community Based Alternatives Provider Manual* and the *Residential Care Provider Manual*.

Supply Source

This form must be printed from the electronic version of the DHS Forms Website.

DETAILED INSTRUCTIONS

Client Name — Enter the client's name as it appears on page 1 of the participant's Form 3671, Individual Service Plan (ISP), or Form 2101, Authorization for Community Care Services – Service Authorization System (SAS).

Medicaid No. — Enter the Medicaid recipient number as it appears on Form 3671, page 1, for CBA AL/RC or on Form 2101 for CCAD RC.

Date of Review — Enter the date the review is being conducted for this client's file in month/day/year format.

Review Period — Enter the month(s) and year(s) being reviewed in month/year format.

Review Type — Mark the appropriate box for the type of review being conducted: Formal or Follow-UP.

Service And Setting Type – Mark the appropriate box for the type of service being reviewed: CCAD RC or CBA AL/RC. Next to the marked box, enter the authorized setting as follows:

CCAD RC –
- Apt. = Apartment
- Non-Apt. = Non-Apartment

CBA AL/RC –
- AL Apt. = Assisted Living Apartment
- RC Apt. = Residential Apartment
- RC Non.-Apt. = Residential Care Non-Apt.

Service Code: Enter the service code found in Cognos - Payments for Monitoring. This will assist with completion of Standard 1 to determine what setting the facility should be billing for

Region – Enter the number of the region to which the facility is assigned.

Co-payment — Enter the correct co-payment for the month(s) being reviewed, as found on Form 2065-B, Notification of CBA Services, or Form 2065-A, Notification of Community Care Services. If the client does not have a co-payment, enter 0.

Vendor No. — Enter the vendor number of the facility being reviewed.

Facility Name — Enter the name of the facility being reviewed.

Monitor — Enter the name of the DHS staff who conducted the review for this client's file.

***No. Contracted Beds*:** Enter the number of beds the facility is contracted for during the review period (Form 3681-A). Pull a Cognos list for each month during the review period (possible amendments) prior to conducting the review to assist with completion of Standard 8b.

Standard Summary – (Optional). At the bottom of page 1, staff may enter the overall compliance for Standards 1 – 7 as**: M** = MET**, NM** = NOT MET or **N/A** = Not Applicable (NA).

Standard 1 – Residence Setting

Prior to the monitoring review, obtain the date the contract was awarded by reviewing the contract and obtain the authorized setting for the client from COGNOS - Payments for Monitoring Report. Form 3681-A indicates the setting and square footage/common areas the facility is contracting for. At the site visit:

- Request from the facility a current floor plan that identifies the DHS contracted beds and client location. The floor plan should include the dimensions of each room to determine if the facility meets the appropriate square footage for the type of setting the client has been authorized to reside in.

For CBA AL/RC

Mark standard 1.a. YES if**:**

- A contract was awarded prior to 09/01/03 and the rooms measured 160 sq. ft. for a facility that remodeled an existing structure;
- A contract was awarded prior to 09/01/03 and the rooms measured at a minimum of 220 sq. ft. for a newly built facility;
- A contract was awarded prior to 09/01/03 and remodeled their facility after 09/01/2003 and the rooms measured at a minimum of 220 sq. ft.; or
- A contract was awarded after 09/01/03 and the rooms measured at a minimum of 220 sq. ft.

For CCAD RC

Mark standard 1.a. NA if:

- A contract was awarded between 03/15/97 to 08/31/03.

Mark standard 1.a. YES if:

- A contract was awarded after 09/01/03 and the room measured at a minimum of 220 sq. ft.

For each item a. through b.:

- Mark YES, NO, N/A or skip an item as instructed on the form;
- Enter comments in the Notes section as appropriate; and
- Review all items, a. – b., as instructed on the form, even if one item causes the overall Standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 1 – Mark the overall standards as MET, NOT MET, or N/A as appropriate.

Standard 2 – Service Initiation

For each item in a. through b.:

- Mark YES, NO, N/A or skip an item as instructed on the form;
- Enter comments in the Notes section as appropriate; and
- Review all items, as instructed on the form, even if one item causes the overall Standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 2 – Mark the overall standard as MET, NOT MET, or N/A as appropriate.

Standard 3 – Co-payment and Room and Board Ledgers

For each item a. through b.:

- Mark YES, NO, N/A, or skip an item as instructed on the form;
- Enter comments in the Notes section as appropriate; and
- Review all items, a. - b. as instructed on the form, even if one item causes the overall Standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 3 – Mark the overall standard as MET, NOT MET, or N/A as appropriate.

Standard 4 — Co-payment and Room and Board Refunds

Complete the table under the notes column, then answer item a.

Table Information:

Review period - Enter the month(s) and year(s) being reviewed in Month/Year format.

A. Authorized Co-payment — Enter the authorized co-payment for the month(s) being reviewed as found on Form 2065-B or Form 2065-A.

B. Co-payment Refund (from previous month): — Enter the amount of any credit that is due. Enter zero (0) if none is due.

C. Adjusted Amount Due (A-B)— Subtract Item B from Item A and enter that amount.

D. Amount Collected — Enter the amount of co-payment collected for the month being reviewed.

E. Credit Balance (+) or Underpayment (-): (D - C) — If Item D is different from Item C, enter the difference.

Date of Written Notice of the Credit Balance: (If applicable) — Enter the date of the written client notice which must be within 35 days of receipt of the payment that resulted in a credit balance.

Item a. Institutionalization is defined as a hospital, nursing facility, state school, state hospital, or intermediate care facility serving persons with mental retardation or a related condition. Review only one month before the review period to determine whether a credit/refund was due. Do not review if the credit/refund is due beyond the review period.

Standard 5 — Co-payment and Room and Board Receipts

Item a. – Enter the review period and the designated due date for co-payment and room and board in the table on the right column of Standard 5.a. Enter N/A if the client does not have a co-payment.

Item a.1. - Enter the date the authorized co-payment amount and the authorized room and board was collected in the table on the right column of Standard 5.a. for each month during the review period. The entire amount must be collected by the designated due date in order for this item to be marked YES. Enter N/A if the client does not have a co-payment.

Standard 5 is NOT MET if both a.1 and a.2 is marked NO. Item a. is MET if item a.1. is marked NO but item a.2. is marked YES.

Item b. Receipts must contain the elements in items b.1. - b.4 if the elements are not contained in the co-payment and room and board ledger.

For each item in a. through b.:

- Mark YES, NO, N/A, or sip an item as instructed on the form;
- Enter comments in the Notes section as appropriate; and
- Review all items, a. – b. as instructed on the form, even if one item causes the overall Standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 5 – Mark the overall standard as MET, NOT MET, or N/A as appropriate.

Standard 6 – Service Delivery Documentation

For each item in a. through f.:

- Mark YES, NO, N/A, or skip an item as instructed on the form;
- Enter comments in the Notes section as appropriate; and
- Review all items, a. – f., as instructed on the form, even if one item causes the overall Standard to be NOT MET. This is to ensure compliance with all rules within this standard.

STANDARD 6 – Mark the overall standard as MET, NOT MET, or N/A as appropriate.

Standard 7 — Individual Client Trust Fund

A. If this item is marked No, Standard 7 is N/A, skip to Standard 8. If this item is marked Yes, continue to item B..

- For items 1-8, determine each amount, using the formula outlined in the "Item" Section. If the dollar amount in item A. 8 is any amount other than $0.00, the appropriate item(s) B. 1.- 6. must be marked NO and comments provided. The comments must indicate the reason for an amount other than $0.00 in item A. 8.

B. Evaluation – Answer items 1. – 6. and provide comments as appropriate. This item is completed regardless of the amount in item A. 8.

- Item B.1. – Determine if the facility has written authorization from the client/client's representative to handle the client's financial affairs.
- Item B.2. – Determine if the facility has a receipt or a deposit slip verifying the amount received on behalf of a client and that all deposits are posted to the client's trust fund ledger.

- Item B.3. – Determine if the facility made any unauthorized withdrawals from the client's trust fund.
- Item B.4. – Determine if the facility has receipts and client authorization (for both single payments and recurring payments) for payments and withdrawals.
- Item B.5. – Determine if the facility made any mathematical errors in the trust fund ledger.
- Item B.6. – Determine if the facility refunded the trust fund balance of a deceased or discharged client with 10 workdays after discharged or date of awareness if deceased.

If the answer to any of the questions in Section B are No, Standard 7 is NOT MET.

Standard 8 — Pooled Client Trust Fund

Complete this only once for the entire facility. Do not figure into the overall percentage.

Facility Name — Enter the name of the facility.

Vendor Number — Enter the vendor number for the contract being reviewed.

Review Period — Enter the period for which the records are being read in month/day/year format (MM/DD/YY).

Review Date — Enter the date this standard was reviewed in month/day/year format (MM/DD/YY).

Monitor — Enter the name of the DHS staff who conducted the review for this standard.

A. If this item is marked No, skip to Standard 8, and mark this standard N/A. If this item is marked Yes, continue to item B.
B. Answer items 1. - 3. as appropriate.

<u>For Item B.3.:</u>

If **no errors in Standard 7**, use the ending monthly balance from the ledgers for each month in the review period to verify the ending balance shown on the bank statement for the corresponding month. If the ledgers and bank statements don't match, reconcile the individual entries on the ledgers to the bank statement.

Review trust fund ledgers for all individuals utilizing the pooled account regardless of whether or not they are a DHS client.

If **any errors are found in Standard 7**, regardless of the type of trust fund account, review the pooled account to verify that all withdrawals and deposits are authorized and allowable, review to ensure the math is correct, etc.

If one or more of the questions in Item B are answered No, mark the standard as NOT MET.

Findings — Explain the problems found in the records that cause the standard to be NOT MET, or list any discrepancies that need to be discussed with the facility representative.

Monitor Signature— The DHS staff who reviewed this standard signs and dates the form when completed.

Facility Representative-Signature — The facility representative signs and dates the form acknowledging he has been informed of the findings. His signature does not signify agreement.

Standard 9 – Facility Standards

Complete this only once for the entire facility. Do not figure into the overall percentage.

For each item in a. through f.:

- Mark YES, NO, N/A, or skip an item as instructed on the form;
- Enter comments in the Notes section as appropriate; and
- Review all items, as instructed on the form, even if one item causes the overall Standard to be NOT MET. This is to ensure compliance with all rules within this standard.

Item a. - Review the facility's monthly posting of activities to determine if the posting was done one week in advance. Facilities must date the calendar the day it is posted to verify it was posted one week in advance. If the review is conducted September 12, 2003, review the posting for September 2003 activities only. Do not review the following month's postings of activities.

Item b. – Review the Cognos Client list and the daily census documentation for a list of DHS clients served during the review period.

Item c. – View the disclosure statement to ensure the facility is in compliance with the CCAD RC or CBA AL/RC program rules.

Item d. – Mark this NOT MET if there is no complaint log.

Item e. and f. – Do not review item f. if there are no complaints during the review period (if item e is marked No).

Item f. – Mark Standard 8 NOT MET if item f.1. or f.2. is marked no for any complaints received from a sample or non-sample client during the review period:

Item f.1. - The facility complaint procedures given to the clients in writing should state when complaints will be investigated and resolved according to their licensure requirements. If none are found in the procedures, the complaint must be investigated and resolved within 5 workdays of receipt of the complaint.

Item f.2. – If the complaint procedures are not provided to the client 12 months between each notification. Example: If the notification was provided to the client October 2002, they must be provided to the client no later than October 2003.

STANDARD 9 – Mark the overall standard as MET or NOT MET as appropriate.

Do not include Standard 9 findings with the other Standard Findings on Form 3853, Contract/Program Compliance Provider Agency Evaluation Summary when determining the overall compliance level. Report Standard 9 findings separately in the findings section of Form 3853. Request the provider agency to develop a corrective action plan if the compliance with standard 9 is NOT MET.